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**Forging Medical Public-Private Relationships in Support of Combatant
Commander Objectives—Getting Past the Vision Statement**

by

Edward J. LaGrou, Major, USAF

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Advisor: Major John Mansuy

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Abstract

The potential merit of medical public-private relationships is widely recognized by joint doctrine, geographic combatant commanders, and several large Non-Governmental Organizations (NGO) yet lasting partnerships remain elusive. While the response of the US government and private aid organizations is consistently generous, it is disparate. One wonders what the full potential of the nation would be if these efforts were effectively coordinated into a cooperative arrangement, particularly in medical missions around the world.

This paper explores the issue of why medical public-private partnerships, specifically between the US military and NGOs, struggle to exist. Literature shows that differences can be mitigated, and in doing so, the concept of lasting medical partnerships can move beyond the combatant commander's vision statement. Using a case study methodology and comprehensive literature review, this paper shows lasting partnerships are built on three essential factors: mission, mutually accepted objectives, and organization. This research considers key differences between the military and NGOs and gleans elements of success from recent operations. Finally, the paper establishes parameters on how such relationships should be built and with whom. While this research does not constitute an official endorsement of any of the agencies mentioned within, it gives both combatant command and medical planners a tool for building future relationships.

Introduction

The United States has never been more involved around the globe in humanitarian assistance missions. Its commitment is reflected throughout the spectrum of US private, public, and government aid, running deeply on all levels. Unabashedly the “single most important actor in the humanitarian relief system, the United States contributes the most money, aid, and logistic assistance to humanitarian efforts around the world.”¹ While the response of US government and private aid organizations is consistently generous, it is also disparate. One wonders what the full potential of the nation would be if these efforts were effectively coordinated into a cooperative arrangement, particularly in medical missions around the world.

The potential merit of medical public-private relationships is widely recognized by joint doctrine, geographic combatant commanders, and several large Non-Governmental Organizations (NGO), yet lasting partnerships remain elusive.² The sincere desire to help those in need is not enough to overcome the many complexities of partnering. Boiled down, the military considers the humanitarian assistance mission as a way to fulfill national strategic objectives. The military commander seeks the military-NGO union to bring the whole of the nation to bear on those objectives. Conversely, the NGO exists to provide assistance in accordance with its own by-laws and without uninvited influence—particularly government bias. At times, the military’s goals are congruent with the NGO’s, thus it becomes possible to complement each other’s strengths. The military’s ability to provide transportation, security, and expeditionary medical care marries well with the NGO’s remarkable knowledge of recruitment, funding, and spirit. It is no surprise that commanders recognize opportunity in these partnerships and seek out lasting relationships.

Three US geographic commands openly seek interagency and NGO partnerships as a command priority. US Africa Command boldly states it seeks to incorporate humanitarian organizations “on common approaches to shared interests.”³ US Southern Command goes further by establishing a Public Private Cooperation program to “enhance the existing efforts in the public and private sectors.”⁴ Finally, US Pacific Command created a Center for Excellence in Disaster Management & Humanitarian Assistance, and highlighted the merit of such partnerships in congressional testimony.⁵ Despite this interest, most of their progress has been with other governmental organizations rather than NGOs, and even then, lasting agreements remain elusive.

This paper explores why medical public-private partnerships struggle to exist. The idea of partnering is not new, as demonstrated by numerous articles documenting opportunities and calls for change, particularly from the military’s standpoint. A comprehensive literature review suggests while the military may show a sincere interest, it is viewed with suspicion by many of the agencies it desires as partners.⁶ These agencies cite neutrality, security, ideology, and intention as the chief obstacles to entering partnerships with the military. Opponents suggest partnerships cannot exist without one or both parties sacrificing “core principles.”⁷ Although the military recognizes these differences, it cannot ignore that it is an instrument of power of the United States and must focus on national security objectives to the point of prejudice. The differences are real, but are they insurmountable?

Purpose of the Research

This research shows that differences can be mitigated, and in doing so, the concept of lasting medical partnerships can move beyond the vision statement. Lasting partnerships are built on three essential factors: mission, mutually accepted objectives, and organization. Using

a case study methodology and comprehensive literature review, this paper provides a framework on which to build or bypass partnerships. This research considers key differences between the military and NGOs and gleans elements of success from recent operations. Finally, the paper establishes parameters on how such relationships should be built and with whom. While this research is not an official endorsement of any of the agencies mentioned within, it gives both combatant command and medical planners a tool for building future relationships.

Research Limitations

The scope of this research is to establish criteria for building partnerships with NGOs that focus on providing medical aid, primarily in the form of humanitarian assistance or disaster relief. Those working on human rights, democracy building, and conflict resolution are not included. In addition, this research does not consider other government organizations in its consideration of partnerships. The character of those organizations and any resulting agreement would be different from that studied in this research.

It should also be noted that case studies examined are limited to medical missions which included both US military medical teams and their NGO equivalents. For example, operations in Somalia and Rwanda were omitted from the study since the US military's primary role was not medical in nature. Conversely, the operations in Indonesia and Pakistan were included since the primary mission of the US military and NGO was medical in nature. The significance of this limitation is that very few missions included both military and NGO medical teams. As a result, conclusions are made based on the limited number of qualifying cases.

Definitions

The research concentrates on lasting medical partnerships between civil-military organizations, but what are they really? The premise of a lasting partnership suggests the

partnership is an amenable, long-standing agreement in which both parties achieve their respective goals while working toward a common purpose. For example, the military's goal to further national strategy is different from the NGO's goal to further its organizational objectives. Despite these differences, the military and NGO share a common purpose to alleviate suffering. For the purposes of this research, a successful partnership has clear limits and expectations, and is capable of taking on operation after operation to the satisfaction of both partners. Further, lasting partnerships are not binding contracts, nor are they one size fits all.

Terminology regarding mission types must also be clarified. Among the many factors clouding the discussion of civil-military partnerships is differences in mission terminology. Military joint doctrine interchangeably uses "humanitarian assistance" to describe disaster relief operations.⁸ To the United Nations (UN) and NGO communities, humanitarian action requires adherence to the core principles of "humanity, neutrality and impartiality."⁹ The military, by definition, is an instrument of the United States Government and cannot claim neutrality or impartiality. Because of this distinction, in the eyes of the NGO, the military can only technically undertake relief missions rather than humanitarian assistance. To avoid confusion throughout this paper, the UN construct is used to denote the difference between these missions.

NGO Background

The NGO is a complex organization that requires further examination in order to understand the context of potential partnerships. The next section examines the NGO's make-up, challenges, and levels of interaction.

Definition and Make-up

NGOs vary widely in scope, goals, size, funding, and affiliation. In general, NGOs can be grouped in four categories: humanitarian assistance, human rights, civil-society and

democracy building, and conflict resolution.¹⁰ In its simplest form, an NGO is “a private, self-governing, not-for-profit organization dedicated to alleviating human suffering; and/or promoting education, health care, economic development, environmental protection, human rights, and conflict resolution; and/or encouraging the establishment of democratic institutions and civil society.”¹¹ They are common only in their desire to make the world a better place. With more than 16,586 NGOs in existence, it is not surprising to have such a generalized definition.¹² In the United States, NGOs typically follow a formalized corporate structure which includes a board of trustees, by-laws, mission statement, and charter. Independent by nature, NGOs “are usually quite clear about their values, their goals, and the purpose of their activities.”¹³ Neutrality is one such area taken very seriously. Their strict adherence to neutrality has “operational value,” allowing them to “gain access and reduce security risks” in conflict environments.¹⁴

Employees are equally diverse. Many are attracted to the NGO culture, one known for valuing independence, flexibility, and mobility. Ironically, the allure of operating in foreign countries, experiencing new cultures, and pursuing a mission that simply inspires parallels traits of their military counterparts. Unlike the military however, NGO field staffs work independently without a formal organizational chain of command. Further, decisions are typically made by consensus and through personal engagement.¹⁵ The resulting anecdotal picture expressed by US diplomats working with NGOs portrays NGO staffs as demanding, committed to their issue, and best approached through personal relationships, small group meetings, and face-to-face contact.¹⁶

Challenges

NGOs have challenges like any other organization. Some of the more significant challenges are capability driven, such as transportation, communications, and security. They

lack organic assets and rely on outside sources for support. This is particularly troublesome in crisis, when helicopters or long-range communication is required.¹⁷ In addition, recent security problems have prompted new approaches, to include conflict-handling techniques and hired security.¹⁸ Finally, there is the matter accountability. Despite their good intentions, unintended things happen. For example, the displacement of Zairian refugees was perpetuated by citizens pretending to be refugees so they could access the camp's "superb" medical clinic, a clinic known for exceeding local standards.¹⁹ While noble at first, improperly managed aid can get so out-of-hand that it destroys local markets or assists the belligerents.²⁰ With so many groups operating in chaotic environments, NGOs face the challenge of not worsening an environment by working outside their charter, through staff indiscretion, or unknowingly aiding antagonists.²¹

Cooperation versus Co-existence

The terms *cooperation* and *co-existence* are quite distinct to NGOs and the UN Office for the Coordination of Humanitarian Affairs (OCHA). While largely uncomfortable with the military, NGOs and OCHA accept the fact that the military often responds to complex emergencies. As a result, OCHA has framed civil-military coordination through the terms cooperation and co-existence.²² Cooperation is the ideal relationship in which all parties share a "common goal and agreed strategy, and all parties accept to work together."²³ Cooperation is the highest form of coordination. If cooperation is not appropriate due to lack of common goals or strategy, then the parties must co-exist in the relief effort. This is important in that co-existence implies competition is minimized through coordination.²⁴

While NGOs seem to prefer co-existence with the military to maintain autonomy, neutrality, etc, they have done tremendous work cooperating with private and public organizations. NGOs worked with the Red Cross and Red Crescent movement to create the

Sphere Project, a charter that established minimum standards in disaster response.²⁵ Further, NGOs regularly cooperate with organizations such as the World Health Organization (WHO), OCHA, and the United States Agency for International Development (USAID) to standardize pharmaceuticals and supplies, and obtain funding. Lastly, NGOs like Project Health

Opportunities for People Everywhere (Project HOPE) and CARE now participate in combined civil-military operations. This cooperation will be explored in depth later in this research.

In examining the NGO's make-up, challenges, and levels of interaction, one can appreciate the difficulty in creating lasting civil-military partnerships. Differences with the military are profound (summarized in Figure 1). The next section of the paper begins the analysis of mission as a starting point in establishing such partnerships.

	US Military	NGO
<i>Guided by</i>	National strategic objectives	Charter and by-laws
<i>Structure</i>	Hierarchical chain of command	Independent field teams
<i>Strength</i>	Can deploy anywhere with organic assets	Works well in local cultures
<i>Weakness</i>	Not well suited for aid missions	Lacks organic assets (trans, comm, security)
<i>Seeks</i>	National interests	Impartiality and Neutrality

Figure 1: Key Differences

Mission

Not all missions are appropriate for medical private-public partnerships. Mission alone will be among the first determinants of whether a partnership can exist. This is an important lesson for the military in particular as it struggles with its expanding disaster assistance role. With increasing expectations to assist in complex emergencies, disaster relief, nation-building, and conflict in general, the military is desperate for credible partnerships on both governmental and non-governmental levels. The military planner faces a daunting question—in what missions are NGO partnerships appropriate?

Mission alone can attract or dissuade potential partners. In particular, scope, risk, objectives, and duration are all significant discriminators. (NOTE: The aspect of objective will be explored later in the paper.) The military, mandated by law to take on the full range of missions, has the ability to task out specific capabilities that are tailored to the mission. NGOs conversely, limit themselves in what or where they operate. Organizational goals, set by their board of trustees define their scope, purpose, and operating limits.²⁶ Regardless of the operating differences, the need to understand the mission is equally critical to the military and the NGO.

The first attribute of mission is its scope—disaster relief, nation-building, etc. While the military's scope encompasses the full range of operations, many NGOs concentrate only on specific activities. Some organizations such as Catholic Relief Services undertake a wide variety of missions with geographical limits.²⁷ Many other NGOs, however, concentrate on a narrow subset with a more limited scope, range, and ability. Scope is the first discriminator.

The second mission attribute is risk. The operating environment can range from a relatively peaceful state (permissive) to exceptionally hostile (non-permissive). Some NGOs strictly limit their risk to permissive environments, whereas others like Medecins Sans Frontieres (MSF, translated Doctors Without Borders) routinely operate in high risk countries. NGOs operating in non-permissive environments depend on their impartiality for their security. The assumption is that they will be spared from undue violence as long as their neutrality is clear to all sides.²⁸ No better example exists for NGOs than violence against aid workers in Afghanistan who were suspected of being allied with the military.²⁹ Risk becomes the second discriminator.

The last aspect of mission is duration. By doctrine, the US military seeks short-term engagements designed to provide medical relief only until indigenous or other capacity can take over.³⁰ Conversely, many NGOs are involved in their area of operations for the long-term. They

seek immersion in the customs and culture of those they support. Often, they incorporate local civilians into their effort, gaining familiarity and trust in exchange.³¹ This is not typical of conventional military operations.

To explore the significance of scope, risk, and duration further, recent operations in Afghanistan and Indonesia will be examined to draw out lessons. In both cases, a relevant medical component existed for each organization yet a partnership only was possible in Indonesia. As each case will show, differences in mission attributes were significant.

Afghanistan & the PRT

After overthrowing the Taliban from power in December 2001, the United States and its coalition partners took on the task of rebuilding one of the world's poorest countries. In May 2003, the US Secretary of Defense, Donald Rumsfeld, declared the US military had transitioned into a stability role. The task of nation building would have an earnest role with assistance of International Security Assistance Forces. Unfortunately, the security situation was far from improved and the mechanisms to effect nation building anything but clear or consistent.

In January 2003, the Provincial Reconstruction Team (PRT) concept was fielded as a means to support nation building and humanitarian efforts. These civil-military teams were designed to coordinate US governmental, coalition, and NGO efforts to develop local government and economic structures, infrastructure, and indigenous capacity. The PRT mission had four goals: "extend the influence of the GoA [Government of Afghanistan], promote a secure environment, encourage reconstruction and development activities, and support security sector reform."³² The medical component of the PRT was one of the major humanitarian and nation building activities, tasked with a range of services from providing care to the villages to reconstruction of local capacity.

The PRT concept was not well received by NGOs despite PRTs being limited in scope to humanitarian aid and nation building (while other military units conducted combat operations). NGOs argued PRTs were misguided and that they blurred the role between military and humanitarian aid organizations, ultimately undermining reconstruction efforts. Further, PRTs “violated the core humanitarian principles of neutrality, impartiality, and independence.”³³ NGOs like MSF and CARE would accept the risks of operating autonomously in a hostile environment as they had for years, but were clear in that they would not risk losing their neutrality by working with a military still engaged in hostilities.³⁴

NGO concerns for losing their neutrality increased as the security situation deteriorated further. Violence gradually worsened after the main effort of the war was declared completed. NGOs were not immune to this escalation in violence and believed any association with the military undermined their security that much more. In June 2004, five workers from MSF were murdered. The next month, after 24 years of work in Afghanistan that included the Soviet occupation, MSF pulled out its staff.³⁵ This negative trend continued with 15 aid workers killed in 2007 and 30 in 2008.³⁶ In November 2008, a report on the situation was released by CARE, a leading NGO that has been in Afghanistan since 1961. In it, CARE cited the “blurring of the lines between a humanitarian presence and a military presence” as one of the reasons violence against aid workers had risen.³⁷ While no direct evidence could be found linking these deaths to NGO cooperation with the military, NGOs remain unwilling to work with the military in providing humanitarian assistance or nation building in Afghanistan.

Before any conclusions can be drawn from Afghanistan, case study limitations must first be understood. The discussion of nation building in non-permissive environments was constrained due to the limited amount of published primary and secondary source material. Considering the

war in Iraq and Afghanistan are ongoing, it will likely be years before this aspect can be fully investigated. Aside from this limitation, there are lessons that can be drawn.

The first point to be taken is risk. NGOs, such as MSF and CARE, are certainly not risk adverse. All parties recognize that risk will always exist and that the greater issue is risk mitigation. While the military provides its own security by organic means, NGOs do not. NGOs rely extensively on impartiality for their security, and alliance with the military, particularly in environments where combat operations are ongoing, jeopardizes that impartiality. Loss of impartiality leads to higher risk, and higher risk exacerbates mission accomplishment. CARE captures this point stating “beyond the safety of staff, insecurity threatens the ability of organizations to implement vital reconstruction and relief projects.”³⁸ Non-permissive environments are just not appropriate to seek civil-military partnerships.

The second point is scope. The Afghanistan mission was complex and constantly evolving. The United States was simultaneously engaged in nation building, humanitarian assistance, and combat operations. Despite the fact that NGOs were also providing humanitarian assistance and nation building, NGOs would not partner with the military. First, the military’s scope was much broader, making it difficult to focus on any one area with NGOs without the others having undue influence. Second, combat operations made alliance too risky of an option for the NGOs. As a result, partnerships have not been possible in such a complex environment.

Indonesian Tsunami

The case of the Indonesian Tsunami highlights disaster relief operations in more semi-permissive environments. At the time of the tsunami, Indonesia’s environment was one of insurgency, civil unrest, and martial law, with anti-American groups present.³⁹ Dr Sheldon Simon, Director of Southeast Asian Research at The National Bureau of Asian Research

summarized the situation as: “the thought of US soldiers on Indonesian soil before the Dec. 26 tsunami would have been unimaginable.”⁴⁰ This next case demonstrates partnerships are indeed possible, even in challenging environments.

The Indonesian Tsunami was devastating by all standards. In the morning hours of December 2004, ten countries in Southeast Asia and Africa were forever changed after a magnitude 9.0 earthquake led to a massive tsunami. When it was all over, 283,000 inhabitants perished and another 1,126,900 displaced. Indonesia bore the worst of it, with 131,000 dead and another 572,000 homeless.⁴¹ The United States dispatched the *USS Abraham Lincoln* Expeditionary Support Group to assist in immediate relief efforts. The US Navy (USN) then dispatched the hospital ship *USNS Mercy* to assist further in the medical recovery effort. The US military, already heavily engaged in Iraq and Afghanistan, reached out for assistance to fill critical medical positions. The effort was aptly named Operation Unified Assistance.

Project HOPE, a United States based NGO who was already working in Indonesia on the recovery effort, teamed up with the USN, creating the first partnership of its kind.⁴² The USN provided the ship, crew, and a cadre of medical professionals. Project HOPE, in turn, recruited 200 civilian medical professionals to staff the *Mercy*.⁴³ One of the largest contributors of civilian medical staff was Massachusetts General Hospital (MGH). Within ten days of Project HOPE’s request, MGH deployed 69 volunteers and accepted the associated financial burden.⁴⁴ This unprecedented partnership supported operations from January to March 2005 in Banda Aceh, and 8-28 April 2005 in Nias.

The partnership was considered a success by several measures. At Banda Aceh, the partners treated “more than 9,500 patients, including more than 285 surgical cases.”⁴⁵ The partners also helped restore local hospital services by repairing equipment and facilities. At

Nias, over 5,000 more patients were treated, with nearly 100 surgical cases. In addition, another local hospital's services were restored by equipment repair technicians.⁴⁶ The collective effort of the military and its partners was later recognized by the Stockholm International Peace Research Institute in its report to OCHA on the effectiveness of military assets.⁴⁷

Discussions on the Indonesia case and Project HOPE are more thorough due to the amount of published work available. While there are still risks in basing conclusions on a limited number of cases, the amount of published work allows a deeper examination from multiple points of view. This examination begins with conclusions regarding mission.

The first point is risk mitigation. Indonesia's environment was semi-permissive at the time of the tsunami. Insurgency and anti-American groups posed significant risks to the operation. The USN mitigated security concerns by flying patients to the ship and moving it out 25 to 30 miles from the coast at night.⁴⁸ USN actions demonstrate that security concerns can be managed in semi-permissive environments in such a way that partnerships are feasible.

The second point to examine is the difference of scope between cases. The Indonesia mission was not as complex as the Afghanistan case because the United States was not militarily engaged. The scope was more straight-forward and within the NGO charter. There simply was never any confusion between the USN and NGO on their mission.

The third point requires further exploration—the partnership with Project HOPE. There were over 400 relief agencies operating in the area. Only one, Project HOPE, agreed to work with the USN, albeit mostly as a recruiter. Why was Project HOPE the only NGO willing to partner with the military during the tsunami? The answers are simpler than one would expect. First, Project HOPE's roots go back to a USN medical officer in World War II. That officer, Dr William Walsh, persuaded President Eisenhower to donate one of the hospital ships to do

humanitarian work. Project HOPE was born and the *S.S. HOPE* sailed until 1974.⁴⁹ Since then, Project HOPE has continued its work around the world, independent from the USN. The nuances do not end there, however. When the USN approached Project HOPE for the tsunami recovery, the NGO had another link to the military. The Project HOPE resource staff recruiters included three retired general officers, one of which was a former US Army Surgeon General and another who was a former Chief of the US Army Nurse Corps.⁵⁰ Project HOPE and the USN were no doubt well served by the familiarity and experience these three retired generals offered in joining the two organizations into a coherent team. The generals no doubt helped frame the partnership's mission in such a way that it could succeed.

The final point learned from the Indonesia case regards mission timing and duration. First, the immediate relief effort was conducted by the *USS Lincoln*, not the *USNS Mercy*. The *USNS Mercy* needed five weeks to travel to Indonesia, thus buying time for the USN and Project HOPE to establish their team. Without the *Mercy's* transit time, Project HOPE may not have been as successful recruiting that size and quality of a group. Second, mission duration was managed upfront by dividing most staff into 30-day rotations.⁵¹ Civilian volunteers were not asked to commit to open-ended contracts, thus alleviating the burden on the volunteers and their employers.

Mission Conclusion

To conclude this section, the mission is an essential factor in partnering. Despite research limitations, several conclusions can still be established. First, low risk, short-term missions within the scope of the NGO charter have the greatest potential for long-term success. Second, medium risk (semi-permissive) missions with limited duration are feasible as long as the risk is

mitigated. Third, high risk missions, particularly where the military remains engaged in hostilities, are not appropriate mission sets for NGO partnerships regardless of scope or duration.

Mutually Accepted Objectives

While the mission's scope, risk, and duration are the litmus tests for determining the feasibility of a partnership, it is the mission's objective that frames the partnership itself. Objectives are distinct from the other aspects of mission in that respective charters, by-laws, doctrine, and guidance limit each party differently, even though those parties may already be working in the same environment. Afghanistan is one example in which the military and NGOs have accepted the scope, risk, and duration of the effort, but are unable to accept the same objective, thus partnerships do not exist. Objectives, therefore, are a distinct discriminator.

Objectives take on several forms in medical humanitarian assistance and disaster relief missions. First, there is an objective tied to achieving the end state of the mission at-hand. For example, in the case of the tsunami, all parties sought to alleviate human suffering and assist in the recovery effort. Second, there is an objective linked to guiding principles for humanitarian assistance and disaster relief efforts. For example, an NGO objective is to adhere to the Sphere guidelines to ensure they meet minimum standards and do no harm.⁵² Last, there is the objective related to the parent organization. Again using the NGO as an example, an important objective is to promote their work to maintain the donor base needed to exist.⁵³ NGOs cannot jeopardize their funding base through poor outcomes, associations, or planning.

Although both parties have objectives, there are important contentions to note between the military and NGO. First, objectives, particularly for the military, change during the course of a mission to adjust to desired end states or operational phases. Changing objectives, therefore, become a moving target for partnerships to manage. Second, military objectives serve national

interests, regardless of the mission. This is an important distinction for NGOs because it violates the principles of impartiality and neutrality, as well as increases concerns that the military will deviate from the accepted objective should national interests change.⁵⁴

To explore the significance of objective, recent operations in Pakistan and Indonesia are examined to draw out lessons. Differences in objectives led to two very different outcomes.

Pakistani Earthquake

On October 8, 2005 the Kashmir region of Pakistan suffered a massive 7.6 magnitude earthquake, killing over 73,000 citizens. Beyond the 128,000 injured, more than 600,000 homes, 350 medical facilities, and nearly 4,000 water systems were destroyed.⁵⁵ The impoverished area had over 3.3 million displaced refugees in a mountainous area known for its harsh winters. Complicating the situation, over 6,400 kilometers of its roadways were lost. The United States quickly pledged its support and on October 21, 2005 deployed military units to include the 212th Mobile Army Surgical Hospital (MASH) to support the relief effort.⁵⁶ Relief agencies were already engaged and working independently.

The Pakistani military, working with OCHA, accepted US military support to alleviate suffering and assist in recovery. In support, the United States flew in 7,000 tons of cargo, flew more than 3,000 helicopter missions moving relief personnel and supplies, and erected support and refugee camp facilities.⁵⁷ In addition, the MASH provided urgent medical care to the refugees, recording over 20,000 patient encounters during their four months in operation.⁵⁸

Differences in objectives became clearer as the relief operation proceeded. While both the military and NGOs shared the same objective to alleviate suffering and assist in recovery, differences in execution became problematic. The first concern was in the capability deployed by the US military. The MASH's operating location required a primary care capability after the

first month.⁵⁹ The US military did not have a primary care platform so it continued employment of its MASH. Exacerbating the situation, the MASH supply inventory did not meet World Health Organization (WHO) disaster recommendations.⁶⁰ The result was a higher standard of care than found locally or provided by other relief agencies. This violates relief guidelines because of the unintended consequences it causes for the local system post recovery.⁶¹ Rather than helping restore the local system, the creation of a different standard leads to problems with survivors who become reluctant to accept the lower standard of care common to their system.⁶² The second concern was also a consequence of having the MASH present. The MASH accepted patients it had the capability to treat even though that care was outside that prescribed by the Pakistani military and UN. For example, a harsh reality that existed was the lack of pediatric critical care assets locally. Despite agreements to the contrary, the MASH would resuscitate critically ill patients that could not be sustained in local facilities or held at the MASH. The resulting friction with local facilities led to their refusal to accept transfers from the MASH.⁶³

Three points are made through this case. The first lesson regards the need for clear objectives, and the subsequent call to adhere to its guidelines. The second point regards outcomes with training. Finally, the third point is teaming. Each will now be examined.

The first lesson is the importance of clear objectives. The follow-on to clear objectives is adhering to the guidance associated with those objectives. In this case, the MASH demonstrated tremendous flexibility in taking on a primary care role, but it missed the importance of keeping to the guidelines established by the Pakistani military and UN. As described, the MASH's nonconformance to local standards had negative consequences. The military must understand and respond to the relief community's accepted guidelines if it is to be taken seriously.

The second point to consider is whether training on OCHA or Sphere standards would have led to a different outcome for the MASH unit. Certainly, the MASH made a difference. Its personnel showed commitment to the effort in both the way they transitioned the platform and the raw number of patients seen. Had the staff been trained on OCHA or Sphere standards, it is likely they would not have made the mistakes noted.

The third point to consider is what teaming could have done to mitigate the MASH's unfamiliarity with the OCHA and Sphere standards. Had the MASH teamed with another organization with experience in these standards, the result may have been different. After all, one of the key attributes of partnering with NGOs is that they can help the military avoid situations going against local practice.⁶⁴

Indonesian Tsunami

The tsunami case demonstrates the importance of mutually accepted objectives from another standpoint. With the hurdle of mission appropriateness being met, the next step was ensuring all parties understood and accepted the objectives of the mission.

The tsunami relief effort was more complex than solely providing medical assistance. The United States had more than 16,000 of its forces aiding the effort.⁶⁵ The USN divided the response into two parts. The immediate response, airlift of supplies, and support to WHO field teams was done by the *USS Abraham Lincoln* Expeditionary Support Group.⁶⁶ The secondary response by the *USNS Mercy* occurred five weeks later and provided public health assistance, medical supplies, and reconstruction of local health services.⁶⁷ The *Mercy's* mission was therefore just a component of the larger USN operation.

With limited objectives, the USN and Project Hope entered a partnership only to face new challenges. Although the main objective to provide medical assistance and restore health

services was clear enough to convince volunteers to join, the USN had to reassure its partners soon into the mission that the objective remained the same.⁶⁸ This confusion arose from delays associated with Indonesia's reluctance to accept additional support from the United States.⁶⁹ Project HOPE volunteers did not understand the broader objective or reasons for delay, after all, they were ready and people were suffering. Frustrations resolved once the volunteers understood it was only Indonesia's approval that was needed rather than a change in objectives.⁷⁰

Aside from the complexity of the relief effort, medical scope became the next challenge. Project HOPE volunteers, unaware of disaster relief treatment standards, assumed patients would be treated without restriction. They were surprised this was not necessarily the case, and that there were criteria for a "suitable" patient.⁷¹ This too was resolved once the staff became familiar with the procedures and constraints of working in a disaster environment. The objective was again clarified when everyone agreed that for those patients accepted there would be no other rules "except the needs of the patient."⁷²

Two lessons stand out from this case. The first point regards timing and scope of the objective. The second point relates to OCHA guidelines. Each will now be discussed.

The first point to examine is how the USN and Project HOPE succeeded despite having military objectives greater than that agreed to in the partnership. In this case, USN assets other than the *USNS Mercy* managed the wider set of objectives. The *USNS Mercy* arrived five weeks later and focused solely on the objective established with Project HOPE.

The second point regards adherence to OCHA guidelines. No direct evidence was found that OCHA disaster guidelines were considered by the *Mercy* team. Clearly the *Mercy* staff understood their role in the relief effort and was careful about the types of patients accepted, but it is unclear on what any of this was based. In a review of military effectiveness in the disaster,

the Stockholm International Peace Research Institute broadly noted that many of the organizations involved in the relief effort were unaware of the OCHA guidelines.⁷³ While the *Mercy* was certainly successful because of having followed guidelines, the effort as a whole could have been better executed had all organizations adhered to accepted OCHA guidelines.

Mutually Accepted Objectives Conclusion

To conclude this section, mutually accepted objectives are essential to establishing any partnership. Further, multiple objectives can exist simultaneously depending on the situation. It is essential that objectives are clear, do not conflict, and have the agreement of all parties.

Organization

The organization of the partnership is the last factor considered. Clear roles, expectations, and structure are especially critical to any agreement. This section explores each element, once again seeking lessons applicable to future partnerships.

In terms of organizational structure, the military and NGOs are quite different. The US military is known for embracing a hierarchal organizational structure, complete with lines of authority, chains of command, and designated specialties. By design, they are able to deploy anywhere and support themselves. In a typical disaster response, the military employs a formal structure such as a Joint Task Force or Expeditionary Support Group with a Civil-Military Operation Center (CMOC) established for coordinating activities with other participants.⁷⁴ In contrast, the NGO desires autonomy for its fielded teams, allowing their charter, by-laws, and situation to guide their effort. Further, NGOs regularly augment their staff with local resources and people to conduct their mission.⁷⁵ Local augmentation allows the NGO to dispatch a smaller staff, and supports their goal to become one with the populace.

The aspect of roles and expectations is another key factor in which differences exist. NGOs seek to identify themselves with the local populace, even enduring the same hardships.⁷⁶ Their commitment is long-term with the goal of providing relief within the local customs and culture and in underserved areas. With the exception of its special forces, the military considers its role differently. Although local culture is considered, the military does not seek to blend into the population or have a long-term commitment. By doctrine, their role is to provide relief until local capabilities are restored.⁷⁷

To explore the significance of organization, three cases are examined. In the first two, the operating structures are explored in the Pakistan and Indonesia relief efforts. The last case considers USN and Project HOPE partnerships since the tsunami.

Pakistani Earthquake

Returning to the Pakistani Earthquake case, the lack of an organizational structure made a difficult situation that much more complicated. By design, structure, roles, and expectations were not strictly planned for or managed. The UN simply did not have many options available.

Pakistan's earthquake response effort was overseen by the Pakistani military, with assistance of OCHA. The challenges were enormous for Pakistan, and this was "particularly the case for a military lacking experience in working with NGOs and unfamiliar with the humanitarian principles they defend."⁷⁸ To overcome this barrier, the UN's Inter-Agency Standing Committee (IASC) Cluster Approach was chosen as the organizational model.

The Cluster Approach was created to "address identified gaps in response and enhance the quality of humanitarian action."⁷⁹ Known as a model of non-interfering coordination, this approach attempts to guide the efforts of disparate groups. The Cluster Approach breaks relief efforts into nine sectors: Nutrition, Health, Water/Sanitation, Emergency Shelter, Camp

Coordination, Protection, Early Recovery, Logistics, and Emergency Telecommunications. Each sector has a lead agency that coordinates related activities within the objectives of the host country. Consistent with UN guidelines, the World Health Organization (WHO) led the Health sector in this response.⁸⁰ As the lead, WHO oversaw the health effort as a whole and ensured no gaps existed in coverage. This was accomplished, in part, by giving NGOs the latitude to choose the type and location of their mission. Gaps were then filled in by foreign military units, to include the United States.⁸¹

Aside from selecting a structure, there was the matter of coordination. On the governmental level, coordination within Pakistan at the onset was slow when it did exist. The result was Pakistan receiving foreign military capabilities it did not require.⁸² Complicating the situation, NGOs and the military generally co-existed rather than cooperated in their effort.⁸³

One central lesson can be drawn from this case. The Cluster Approach, an undeniably useful model, does not equate to partnering. The model works because it accepts co-existence rather than try to create partnerships. In a report supported by OCHA, it was noted that many of the NGOs “saw a need to distance themselves” from the military even when they worked aside them.⁸⁴ They were concerned by the impression of having an association with the military, potentially jeopardizing their ability to work in some parts of the world. The Cluster Approach gives NGOs that room to co-exist without sacrificing coordination.

Indonesian Tsunami

Returning to the Indonesian Tsunami, the matter of organization was instrumental in making the partnership work. With the hurdles of mission appropriateness and mutually accepted objectives met, the partners next established roles, expectations, and structure. Again, they succeeded despite having to build their organization from scratch.

Establishing clear roles was the first step in developing this historic partnership. They divided across strengths. The USN provided the facilities, equipment, security, and training, and had responsibility for the overall operation. Project HOPE, in turn, provided licensed staff which were appropriately credentialed and screened for the mission. This included transportation to the port embarkation and coordination activities while underway.⁸⁵ Once on board the ship, teams were structured by specialty rather than by military or civilian affiliation.

Preparation for the mission was another foundational step in creating a successful organizational construct. Although no published organizational structure or diagram could be found during research, primary sources inferred one existed. A USN Captain commanded the medical staff and hospital functions.⁸⁶ Civilian staff members were overseen by Project HOPE's resource staff. All staff, regardless of position, took on shared responsibilities typical of being underway.⁸⁷ This included cleaning the sleeping and living areas. These roles and expectations were established in two days of briefings outlining their mission, safety and security, shipboard operations, military familiarization, and even likely psychological stressors they would face.⁸⁸

Once underway, the team continued to refine their organization. By the end of their second month, "mission and common operation procedures were established, a command and control configuration determined, battle rhythm shaped, communications channel created, inter- and intra-team coordination accomplished, and diplomatic channels with the Indonesian military, Ministry of Health, and recovery agencies opened."⁸⁹ While one would argue these should have been in place prior to embarking, it is impressive that this group formed a partnership in a time of crisis and channeled their problems into solutions while underway. This template was successfully applied in tsunami relief effort in Banda Aceh and Nias.

This case offers several lessons. First, roles and structure were flexible, shifting from preparation to execution during the operation. This allowed each organization to concentrate on their strengths early in the mission, and then combine into a cohesive team prior to execution. Second, the clarity and consistency of their roles not only improved processes, but helped build confidence and trust over the course of the two tsunami missions. The third point is one of expectations, specifically with their volunteers. Although they were living and working on a naval vessel, they were in fact in a hospital that “rivalled the equipment and facilities at MGH.”⁹⁰ With proper screening, in-depth orientation, and tools of a modern medical facility at their disposal, the USN fully utilized civilian volunteers successfully in a disaster relief operation.

US Navy – Project HOPE

The experiences between USN and Project HOPE since the tsunami denote the effectiveness of clear roles and expectations. Since the Indonesian tsunami missions, they have applied their organizational approach several other times on behalf of US Northern Command, US Southern Command, and US Pacific Command. First, they responded to Hurricane Katrina in 2005. Then, realizing the potential of their partnership, they cooperated twice more in support of combatant command goodwill missions in Latin American and the Pacific. These missions were different in that they provided health care and education to coastal communities rather than disaster relief.⁹¹

It can be argued that much of their success is derived from the way they organize differently in preparation versus execution. This tested model has been executed three additional times since the tsunami. In preparing, the USN and Project HOPE worked in parallel on different activities. While the USN planned the mission, obtained clearances, and readied its own personnel, Project HOPE worked recruitment. Prior to embarking, they transitioned the

group into a single team through a series of briefings and exercises designed to familiarize the group to the ship and mission.⁹² At execution, teams are organized by function, with military and civilian staff mixed accordingly. The clarity of their roles throughout the process is no doubt significant to their success in taking on such varied missions, not to mention with volunteers.

The consistency of Project HOPE's role in the partnership is also important. In each of the USN missions, Project HOPE had responsibility for recruiting a volunteer mix appropriate to the mission. This is a complex role considering these are health care professionals being recruited from active roles in hospitals and clinics across the country. Project HOPE had to screen candidates, verify credentials, and secure agreements with the releasing facilities and volunteers. Beyond securing the support from these facilities, Project HOPE ensured the volunteers had a passport, were current and licensed in their medical specialty, had applicable immunizations for the operation, and had a leave of absence for the duration of the mission.⁹³ This role was consistent and effective in both tsunami missions, Hurricane Katrina, and the goodwill missions in Latin America and the Pacific Rim. Further, research uncovered no problems in the specialty mix, credentialing or quality of the volunteers.

The last point to explore is management of expectations. The USN and Project HOPE successfully organized a cohesive team each time. This is one of the more difficult areas to manage. First, there is the complexity of three unique groups, the USN, Project HOPE, and the civilian volunteers. Each group views the mission and their role through a different lens, so misunderstandings are inevitable. Going back to the tsunami, volunteers expressed frustration due to the "trial and error" integration with the military, and difficulties associated with open sleeping bays, life aboard ship, and the stress of being in transit to the disaster.⁹⁴ These

comments are significant in that frustrations were not over the mission or its objectives. They were over integration and were a product of the stresses of responding to a disaster.

Organization Conclusions

Concluding this section, a structure built on clear roles helps mitigate unrealistic expectations and friction. When loosely managed, unintended consequences occur to the detriment of the mission. When done well, the structure can be successfully applied across varied operations, as demonstrated by the USN-Project HOPE partnership.

Recommendations for Future Study

If future successful partnerships in disaster relief operations are desired, additional research is needed in several areas. These areas are important in that they clarify the cost and difficulty of future partnerships as they relate to specific military platforms and training. The following questions deserve further examination:

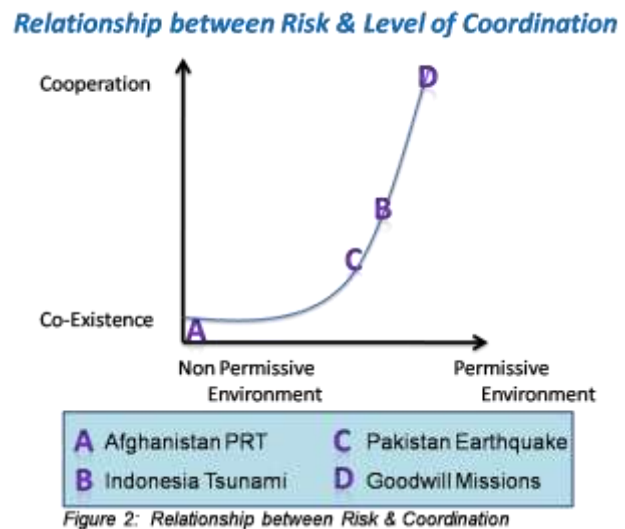
1. What logistics (medical and supplies) gaps exist between recommendations made by OCHA and WHO and that stocked in military medical platforms? Further, what is required to close that gap (i.e. cost, law, doctrine)?
2. What is the feasibility of training military personnel on Project Sphere and OCHA guidelines? Does having the training improve capability or credibility in the field?
3. Can the hospital ship missions be as successful utilizing the USA's Combat Support Hospital or USAF's Expeditionary Medical Support (EMEDS) hospital?

Summary and Conclusions

As demonstrated through case studies, there are significant complexities in partnering. Opponents argue that partnerships between the military and NGOs are inappropriate and should be avoided out of respect for the differences in why each exists. To enter such a relationship

NGOs would essentially be “abandoning core principles,”⁹⁵ The evidence is in their favor. So why press with the issue? The answer is duty. The US military has a duty to do what our nation asks. The military carries this charge because they are the only instrument of power equipped to deploy on a moment’s notice and conduct operations anywhere in the world for those in need. Further, it has been shown that partnering can work for parties willing to try.

Partnerships between the US military and NGOs are certainly possible, as seen between the USN and Project HOPE. This is not to say partnerships are easy, or appropriate for a wide range of operations. As the illustration shows, partnerships at the cooperative level are more likely to exist (and succeed) in permissive environments when mission, objectives, and organizational factors align. Conversely, the military will struggle to



reach even the lowest level of coordination (co-existence) with NGOs when engaged in hostilities. Each aspect studied (mission, objectives, and organization) has clearly defined boundaries and it is essential each be considered. Based on the cases reviewed, planners should consider the following recommendations (in no priority order) in determining the feasibility and parameters of future partnerships:

1. The US military must understand, and be able to address, NGO concerns for impartiality and neutrality to be a credible partner in prospective missions. If this is not possible, co-existence is logically the only option available.

2. To be a good partner, the US military needs to train on and conform to OCHA guidelines for disaster relief. This helps with credibility and increases the chance of success in future missions, particularly for those utilizing the UN Cluster Approach.

3. The US military must recognize the limited subset of missions appropriate for partnership. Only narrowly defined missions with mutually accepted objectives are achievable. Complex missions such as nation building in non- or semi-permissive environments are not appropriate due to the many security concerns created for the NGO.

4. Clear, consistent roles and expectations are essential for building confidence and trust in any partnerships that are formed. They must be addressed at every level—the military, the NGO, and the volunteers.

5. Timing and duration of prospective missions need to be addressed with flexible options. The military needs to be realistic that no one else deploys as quickly, in the same way, or with open-ended tour lengths.

6. NGOs with prior association to the military are more likely to be open to partnerships. Association may be organizational in scope like Project HOPE's founding by a naval officer, or it may be personal in scope like the retired USA Surgeon General who assisted with recruiting.

7. Partnership has a range. It does not have to be all or nothing. Following OCHA guidelines, the parties can co-exist or cooperate. Depending on the mission, co-existence may be enough. Only in the best of situations will full cooperation be possible.

8. Terminology must be clear. The military would be better served if it adopted UN humanitarian and disaster relief definitions accepted by the relief community. Regardless of if or when that can happen, planners must be cognizant of their terminology when working medical missions with NGOs.

In conclusion, successful medical public-partnerships are possible when the above parameters are taken seriously. Combatant Commanders are already seeing their vision statement take life in USN and Project HOPE humanitarian goodwill missions. With several missions behind them, their partnership continues to grow as a model for others to follow. The whole of nation is here, proven, and ready to wrap American's arms around those in need.

Endnotes

¹ DiPrizio, Robert C. *Armed Humanitarians: U.S. Interventions from Northern Iraq to Kosovo* (Baltimore, MD: Johns Hopkins University Press, 2002), 11-12.

² Claim supported by seven references: 1) Joint Publication (JP) 3-07.6, *Joint Tactics, Techniques, and Procedures for Foreign Humanitarian Assistance* (Washington DC: Department of Defense, August, 15 2001), I-3. // 2) U.S. Africa Command. "About AFRICOM." <http://www.africom.mil/AboutAFRICOM.asp> (accessed November 10, 2008). // 3) U.S. Pacific Command. "Fact Sheet." <http://www.pacom.mil/about/pacom.shtml> (accessed November 10, 2008). // 4) U.S. Southern Command. "Missions: Public/Private Cooperation." <http://www.southcom.mil/AppsSC/pages/ppc.php> (accessed November 10, 2008). // 5) Fallon, William ADM. "Congressional Testimony: Statement of Admiral William J Fallon Before the Senate Armed Services Committee on U.S. Pacific Command Posture." (USPACOM, March 7, 2006.), 23. Available from <http://www.pacom.mil/speeches/sst2006/DAR-FY07-Fallon%2003-07-06.pdf> (accessed November, 10 2008). // 6) Byman, Daniel, Ian Lesser, Bruce Pirnie, Cheryl Benard, Matthew Waxman. *Strengthening the Partnership: Improving Military Coordination with Relief Agencies and Allies in Humanitarian Operations* (Santa Monica: RAND, 2000), 67. // 7) *National Military Strategy of the United States of America* (Washington DC: Department of Defense, May 2004), 7.

³ USAFRICOM website, "About AFRICOM", 1.

⁴ USSOUTHCOM website, "Missions: Public/Private", 1.

⁵ Claim supported by two references: USPACOM website, "PACOM Fact Sheet"; and Fallon, "Congressional Testimony", 23.

⁶ Byman, "Strengthening the Partnership", 67.

⁷ De Torrente, Nicolas. "Humanitarian NGOs Must Not Ally With Military," *European Affairs*, Spring/Summer 2006, 2.

⁸ JP 3-07.6, I-3.

⁹ Inter-Agency Standing Committee. *Civil-Military Relationships in Complex Emergencies*, United Nations Office for the Coordination of Humanitarian Affairs, March 7, 2008, 10, <http://ochaonline.un.org/Searchresults/tabid/1447/language/en-US/Default.aspx?Search=civil-military+relationship> (accessed January 19, 2009).

¹⁰ Aall, Pamela, Lt Col Daniel Miltenberger, Thomas Weiss. *Guide to IGOs, NGOs, and the Military in Peace and Relief Operations* (Washington DC: United States Institute of Peace, 2001), 94.

¹¹ Ibid., 84.

¹² Ibid., 89.

¹³ Ibid., 95.

¹⁴ De Torrente, "Humanitarian NGOs Must Not Ally", 1.

¹⁵ Aall, "Guide to IGOs NGOs," 97.

¹⁶ Fitzduff, Mari and Cheyanne Church. *NGOs at the Table* (New York: Rowman & Littlefield Publishers Inc, 2004), xiii, xiv.

¹⁷ Aall, "Guide to IGOs NGOs," 108.

¹⁸ Ibid., 109.

¹⁹ Byman, "Strengthening the Partnership", 78.

²⁰ Heyse, Liesbet. "Beyond the Age of Humanitarianism: Past Trends and Future Challenges," *Journal of Contingencies and Crisis Management*, vol 11, no. 4 (December 2003): 1.

²¹ Aall, "Guide to IGOs NGOs," 111.

²² IASC, "Civil-Military Relationships," 5.

²³ Ibid., 6.

²⁴ Ibid., 6.

²⁵ Sphere Project, "*The Sphere Project*," <http://www.sphereproject.org/> (accessed January 19, 2009).

²⁶ Aall, "Guide to IGOs NGOs," 95.

²⁷ Ibid., 94.

²⁸ De Torrente, "Humanitarian NGOs Must Not Ally", 1.

²⁹ Ibid., 4.

³⁰ JP 3-07.6, "*Joint Tactics, Techniques*" IV-20.

³¹ Aall, "Guide to IGOs NGOs," 103.

³² DiPrizio, Robert C. "Provincial Reconstruction Teams in Afghanistan and Iraq: Past Performance, Future Promise." In *Applied Warfare Course* coursebook, edited by Sharon McBride, 181-190. (Maxwell AFB, AL: Air University Press, October 2008), 182.

³³ Ibid., 181, 184.

³⁴ Claim supported by two references: 1) De Torrente, "Humanitarian NGOs Must Not Ally", 3.; CARE, "Afghanistan Special Report," <http://www.care.org/newsroom/specialreports/afghanistan/> (accessed January 19, 2009).

³⁵ Left, Sarah. "Medecins Sans Frontieres to Leave Afghanistan," *Guardian*, July 28, 2004, 1. Available from <http://www.guardian.co.uk/society/2004/jul/28/internationalaidanddevelopment.afghanistan/print> (accessed January 19, 2009).

³⁶ CARE, "Military 'hearts and minds' operations placing ordinary Afghans and aid workers at risk, confirms new report." CARE, November 28, 2008, 1, <http://www.reliefweb.int/rw/rwb.nsf/db900sid/JBRN-7LSKGA?OpenDocument&rc=3&cc=afg> (accessed January 19, 2009).

³⁷ CARE, "Afghanistan Special Report," <http://www.care.org/newsroom/specialreports/afghanistan/> (accessed January 19, 2009).

³⁸ CARE, "Afghanistan Special Report," 1.

³⁹ Morrow, Robert C. "Tsunami Overview," *Military Medicine*, vol 171, (October 2006): 7.

⁴⁰ Simon, Sheldon W. "U.S.-Southeast Asia Relations: Aid Burnishes U.S. Image but Other Concerns Persist," *Comparative Connections*, vol. 7, no. 1 (April 2005): 59.

⁴¹ Morrow, "Tsunami Overview", 5-6.

⁴² Project HOPE. "Humanitarian Assistance Program... at a glance," <http://www.projecthope.org/media/pdf/humanitarianassistance.pdf> (accessed January 17, 2009).

⁴³ Farrell Jr, Lawrence P. "Non-Government Aid Crucial To Disaster Relief Operations," *National Defense*, June 2008, 6.

- ⁴⁴ Wong, Waichi. "Massachusetts General Hospital Participation in Operation Unified Assistance for Tsunami Relief in Banda Aceh, Indonesia," *Military Medicine*, vol 171, (October 2006): 39.
- ⁴⁵ Kissane, Jonathan M. "A Mission with Mercy: A Unique U.S. Partnership for Aiding Tsunami Victims," *Public Manager*, Summer 2005, 7.
- ⁴⁶ *Ibid.*, 8.
- ⁴⁷ Wilharta, Sharon, Hassan Ahmad, Jean-Yves Haine, Josefina Lofgren and Tim Randall. *The Effectiveness of Foreign Military Assets in Natural Disaster Response* (Solna, Sweden: Stockholm International Peace Research Institute, 2008), 97.
- ⁴⁸ Yates, Michael. "Medical-Surgical Nurses Volunteer to Aid Tsunami Victims," *MEDSURG Nursing*, vol 14, no. 5, (October 2005): 332.
- ⁴⁹ Project HOPE, "Our Mission," 1.
- ⁵⁰ Yates, "Medical-Surgical Nurses," 332.
- ⁵¹ *Ibid.*, 332.
- ⁵² Sphere Project, "The Sphere Project," 1.
- ⁵³ Aall, "Guide to IGOs NGOs," 98-99.
- ⁵⁴ *Ibid.*, 116.
- ⁵⁵ MacLeod, Andrew. "Early recovery from disaster: the Pakistan earthquake," *Forced Migration Review*, issue 29, (December 2007): 38.
- ⁵⁶ Fernald, John P. and Elizabeth A. Clawson. "The Mobile Army Surgical Hospital Humanitarian Assistance Mission in Pakistan: The Primary Care Experience," *Military Medicine*, vol 172, (May 2007): 471.
- ⁵⁷ Brooks, Peter. "Hearts and Minds," The Heritage Foundation, 27 December 2005. Available from <http://www.heritage.org/Press/Commentary/ed122705a.cfm> (accessed November 10, 2008).
- ⁵⁸ Fernald, "The Mobile Army Surgical", 471.
- ⁵⁹ *Ibid.*, 471.
- ⁶⁰ *Ibid.*, 476.
- ⁶¹ Wilharta, Sharon, "The Effectiveness of Foreign Military," 117.
- ⁶² *Ibid.*, 117.
- ⁶³ Fernald, "The Mobile Army Surgical", 476.
- ⁶⁴ Byman, "Strengthening the Partnership," 78.
- ⁶⁵ Simon, "Aid Burnishes U.S. Image," 59.
- ⁶⁶ *Ibid.*, 59.
- ⁶⁷ Kissane, "A Mission with Mercy", 5.
- ⁶⁸ Wong, "Massachusetts General Hospital," 37.
- ⁶⁹ *Ibid.*, 38.
- ⁷⁰ *Ibid.*, 38.
- ⁷¹ *Ibid.*, 38.
- ⁷² *Ibid.*, 38.
- ⁷³ Wilharta, Sharon, "The Effectiveness of Foreign Military," 97.
- ⁷⁴ Joint Publication 3-57, *Civil Military Operations*, (Washington DC: Department of Defense, July 8, 2008), II-26-II-28.

⁷⁵ Aall, "Guide to IGOs NGOs," 117.

⁷⁶ Ibid., 105.

⁷⁷ JP 3-07.6, "Joint Tactics, Techniques" IV-20.

⁷⁸ MacLeod, "Early Recovery From Disaster," 38.

⁷⁹ Inter-Agency Standing Committee. *Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response*, United Nations Office for the Coordination of Humanitarian Affairs, November 24, 2006, 1, <http://ochaonline.un.org/Searchresults/tabid/1447/language/en-US/Default.aspx?Search=cluster+approach> (accessed January 19, 2009).

⁸⁰ Ibid., 3.

⁸¹ MacLeod, "Early Recovery From Disaster," 38.

⁸² Wilharta, Sharon, "The Effectiveness of Foreign Military," 118.

⁸³ Ibid., 117.

⁸⁴ Wilharta, "The Effectiveness of Foreign," 117.

⁸⁵ Kissane, "A Mission with Mercy", 5.

⁸⁶ Ibid., 5.

⁸⁷ Yates, "Medical-Surgical Nurses," 332.

⁸⁸ Wong, "Massachusetts General Hospital," 37.

⁸⁹ Morrow, "Tsunami Overview," 6.

⁹⁰ Wong, "Massachusetts General Hospital," 38.

⁹¹ Farrell, "Non-Government Aid Crucial," 6.

⁹² Wong, "Massachusetts General Hospital," 37.

⁹³ Yates, "Medical-Surgical Nurses," 332.

⁹⁴ Claim supported by two references: 1) Wong, "Massachusetts General Hospital," 39. // and 2) McGuinness, Kevin M. "The USNS Mercy and the Changing Landscape of Humanitarian and Disaster Response," *Military Medicine*, vol 171, (October 2006): 50.

⁹⁵ De Torrente, "Humanitarian NGOs Must Not Ally", 2.

Bibliography

- Aall, Pamela, Lt Col Daniel Miltenberger, Thomas Weiss. *Guide to IGOs, NGOs, and the Military in Peace and Relief Operations*. Washington D.C.: United States Institute of Peace, 2001.
- Brooks, Peter. "Hearts and Minds." *Heritage.org*, 27 December 2005. <http://www.heritage.org/Press/Commentary/ed122705a.cfm> (accessed November 10, 2008).
- Byman, Daniel, Ian Lesser, Bruce Pirnie, Cheryl Benard, Matthew Waxman. *Strengthening the Partnership: Improving Military Coordination with Relief Agencies and Allies in Humanitarian Operations*. Santa Monica: RAND, 2000.
- CARE, "Military 'hearts and minds' operations placing ordinary Afghans and aid workers at risk, confirms new report." *Relief.int*, November 28, 2008. <http://www.reliefweb.int/rw/rwb.nsf/db900sid/JBRN-7LSKGA?OpenDocument&rc=3&cc=afg> (accessed January 19, 2009).
- CARE, "Afghanistan Special Report." *Care.org*. <http://www.care.org/newsroom/specialreports/afghanistan/> (accessed January 19, 2009).
- De Torrente, Nicolas. "Humanitarian NGOs Must Not Ally With Military." *European Affairs*, Spring/Summer 2006.
- DiPrizio, Robert C. *Armed Humanitarians: U.S. Interventions from Northern Iraq to Kosovo*. Baltimore, MD: Johns Hopkins University Press, 2002.
- DiPrizio, Robert C. "Provincial Reconstruction Teams in Afghanistan and Iraq: Past Performance, Future Promise." In *Applied Warfare Course* coursebook, edited by Sharon McBride, 181-190. Maxwell AFB, AL: Air University Press, October 2008
- Fallon, William ADM. "Congressional Testimony: Statement of Admiral William J Fallon Before the Senate Armed Services Committee on U.S. Pacific Command Posture." USPACOM, 7 Mar 06. Available from <http://www.pacom.mil/speeches/sst2006/DAR-FY07-Fallon%2003-07-06.pdf> (accessed November, 10 2008.)
- Farrell Jr, Lawrence P. "Non-Government Aid Crucial To Disaster Relief Operations." *National Defense*, June 2008, 6.
- Fernald, John P. and Elizabeth A. Clawson. "The Mobile Army Surgical Hospital Humanitarian Assistance Mission in Pakistan: The Primary Care Experience." *Military Medicine* vol 172, May 2007, 471-477.
- Fitzduff, Mari and Cheyanne Church. *NGOs at the Table*. New York: Rowman & Littlefield Publishers Inc, 2004.

Heyse, Liesbet. "Beyond the Age of Humanitarianism: Past Trends and Future Challenges." *Journal of Contingencies and Crisis Management* vol 11, no. 4, December 2003, 1-4.

Inter-Agency Standing Committee. *Civil-Military Relationships in Complex Emergencies*. United Nations Office for the Coordination of Humanitarian Affairs, March 7, 2008, 10, <http://ochaonline.un.org/Searchresults/tabid/1447/language/en-US/Default.aspx?Search=civil-military+relationship> (accessed January 19, 2009).

Inter-Agency Standing Committee. *Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response*." United Nations Office for the Coordination of Humanitarian Affairs, November 24, 2006, 1, <http://ochaonline.un.org/Searchresults/tabid/1447/language/en-US/Default.aspx?Search=cluster+approach> (accessed January 19, 2009).

Kissane, Jonathan M. "A Mission with Mercy: A Unique U.S. Partnership for Aiding Tsunami Victims." *Public Manager*, Summer 2005, 4-9.

Left, Sarah. "Medecins Sans Frontieres to Leave Afghanistan." *Guardian*, July 28, 2004. Available from <http://www.guardian.co.uk/society/2004/jul/28/internationalaidanddevelopment.afghanistan/print> (accessed January 19, 2009).

Joint Publication 3-0, *Joint Operations*, September 17, 2006.

Joint Publication 3-07.6, *Joint Tactics, Techniques, and Procedures for Foreign Humanitarian Assistance*, August, 15 2001.

Joint Publication 3-57, *Civil Military Operations*, July 8, 2008.

MacLeod, Andrew. "Early recovery from disaster: the Pakistan earthquake." *Forced Migration Review*, December 2007, issue 29, 38-39.

McGuinness, Kevin M. "The USNS Mercy and the Changing Landscape of Humanitarian and Disaster Response." *Military Medicine*, vol 171, October 2006, 48-52.

Morrow, Robert C. "Tsunami Overview." *Military Medicine*, vol 171, October 2006, 5-7.

National Military Strategy of the United States of America. Washington DC: Department of Defense, May 2004.

Project HOPE. "Humanitarian Assistance Program... at a glance." *Projecthope.org*. <http://www.projecthope.org/media/pdf/humanitarianassistance.pdf> (accessed January 17, 2009).

Simon, Sheldon W. "U.S.-Southeast Asia Relations: Aid Burnishes U.S. Image but Other Concerns Persist." *Comparative Connections*, vol. 7, no. 1, April 2005, 59.

Sphere Project, "*The Sphere Project*." *Sphereproject.org* (accessed 19 January 2009).

- United Nations Office for the Coordination of Humanitarian Affairs. "Humanitarian Issues." *OCHAonline.org*. <http://ochaonline.un.org/HumanitarianIssues/tabid/1081/Default.aspx> (accessed January 18, 2009).
- U.S. Africa Command. "About AFRICOM." <http://www.africom.mil/AboutAFRICOM.asp> (accessed November 10, 2008).
- U.S. Pacific Command. "Fact Sheet." <http://www.pacom.mil/about/pacom.shtml> (accessed November 10, 2008).
- U.S. Southern Command. "Missions: Public/Private Cooperation." <http://www.southcom.mil/AppsSC/pages/ppc.php> (accessed November 10, 2008).
- Vego, Milan. "Military Objectives and the Levels of War." In *Joint Campaign Planning* coursebook, edited by Sharon McBride, 20-40. Maxwell AFB, AL: Air University Press, January 2009.
- Wilharta, Sharon, Hassan Ahmad, Jean-Yves Haine, Josefina Lofgren and Tim Randall. "The Effectiveness of Foreign Military Assets in Natural Disaster Response." Solna, Sweden: Stockholm International Peace Research Institute, 2008.
- Wong, Waichi. "Massachusetts General Hospital Participation in Operation Unified Assistance for Tsunami Relief in Banda Aceh, Indonesia." *Military Medicine*, vol 171, October 2006, 37-39.
- Yates, Michael. "Medical-Surgical Nurses Volunteer to Aid Tsunami Victims." *MEDSURG Nursing*, vol 14, no. 5, October 2005, 331-334.